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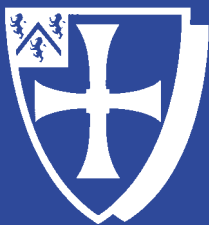
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Occasional Paper No. 2 - May 2001

A Review of the National Inequalities Target

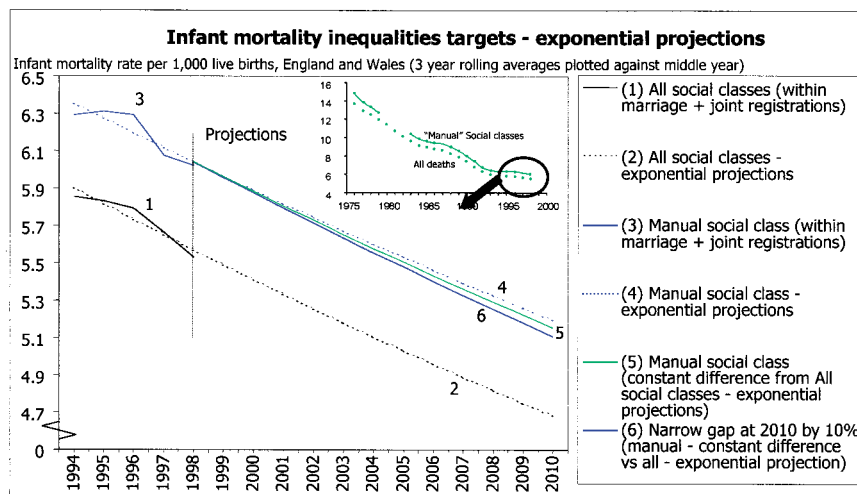
Background

The Government gave a commitment in the "NHS Plan"¹ that, for the first time ever, local targets for reducing health inequalities would be reinforced by the creation of national health inequalities targets. These were announced in a speech² by the Right Honourable Alan Milburn MP, Secretary of State for Health, and an accompanying Press Notice³ on 28 February 2001.

The National Health Inequalities Targets⁴

Infant Mortality - "Starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between manual groups and the population as a whole."

The graph below (taken from the briefing paper⁴) shows the basis on which this target was calculated.



In setting this target, the Secretary of State for Health has said² that the Government expects the national infant mortality rate to fall for the first time below 5 deaths per thousand live births by 2006 and to result in approximately 3000 children's lives being saved by 2010. It will be monitored annually.

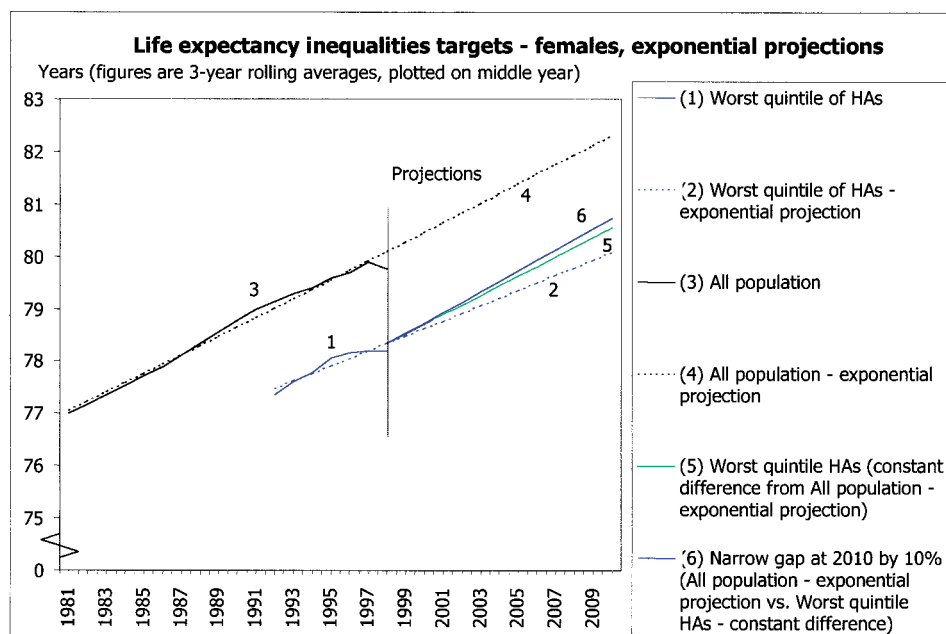
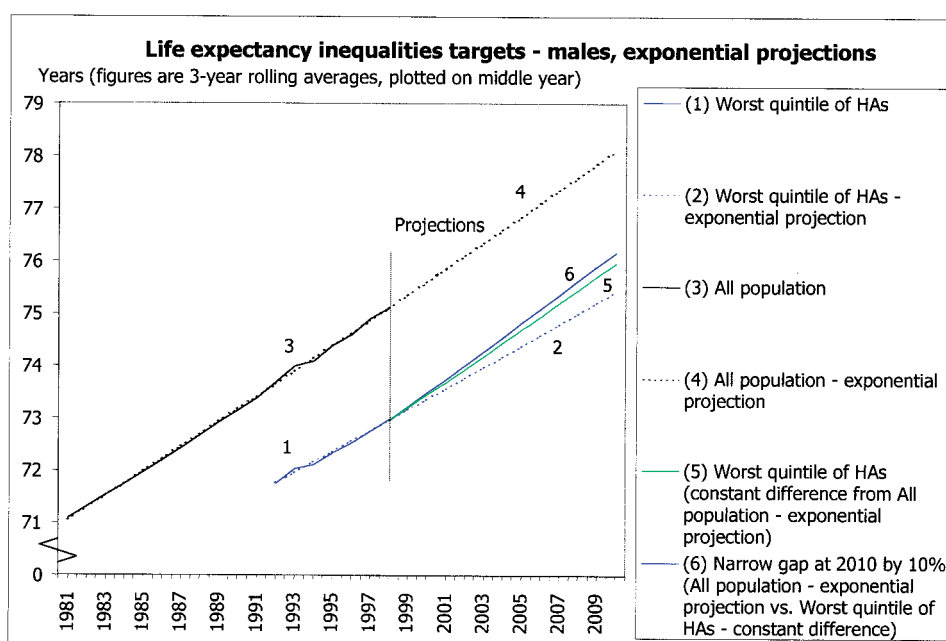
Infant mortality reflects a range of influences within and outside of the health service. The Department of Health has said that success in achieving the target should be a measure of progress across a much broader front than the immediate measure of mortality in a very restricted age group.

Interventions intended to contribute towards meeting the target will include:

- Smoking control;
- Improved uptake and continuation of breast feeding;
- Parental support by health visitors and community;
- Reduced poverty;
- Improved maternal mental health; and
- Better access to health care, including antenatal care, paediatric care and neonatal intensive care.

Expectation of life - "Starting with Health Authorities, by 2010 to reduce by at least 10% the gap between the quintile of areas with the lowest life expectancy at birth and the population as a whole."

The graphs below (taken from the briefing paper⁴) show the basis on which this target was calculated.



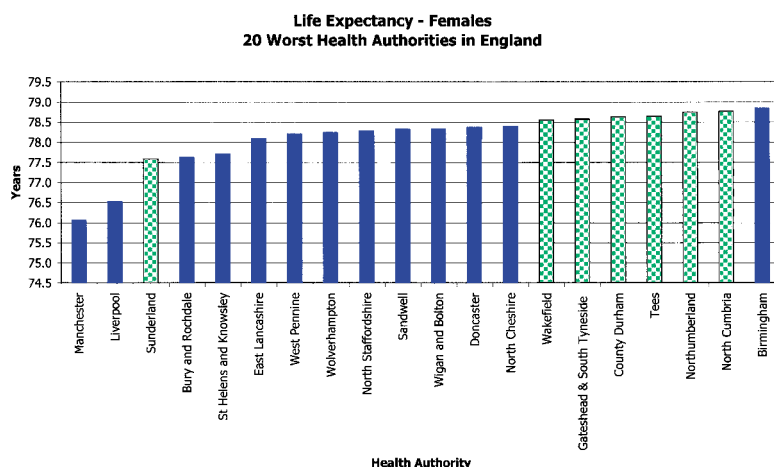
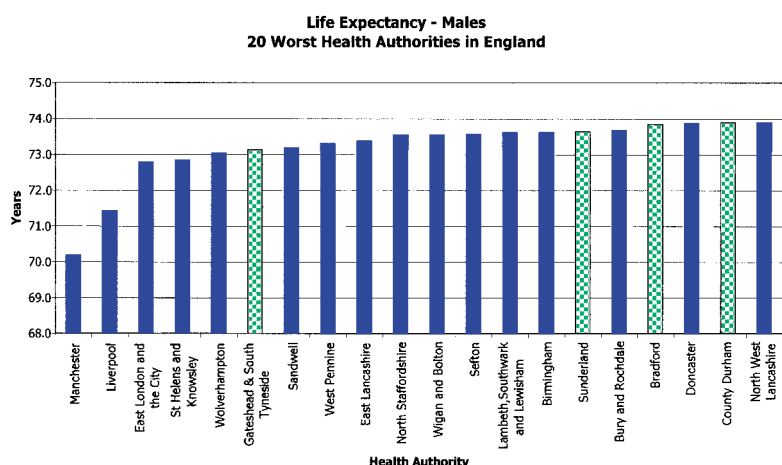
The average life expectancy in the bottom quintile of Health Authorities is currently only at the level reached by the total population nine years previously. If the target is to be achieved by 2010, on the basis of current trends, this would reduce this figure by about one year. Extrapolation of recent trends suggests a widening of the gap for both men and women between the bottom quintile and the population as a whole. An overall measure of the reduction in health inequality fits with targets being adopted in other countries and proposed by the World Health Organisation. This area-based target will form part of the Department's Government Interventions in Deprived Areas (GIDA)⁵ commitment. Interventions will include:

- The Cancer Plan⁶;
- Smoking cessation initiatives⁷; and
- Wider opportunities including Sure Start⁸ and Neighbourhood Renewal⁹.

Local Data

Local data are not yet available for the calculation of these targets at a more local level. However, the numbers involved (particularly of infant deaths) will mean calculation of targets at small population levels will be difficult.

The graphs below show the current bottom quintile of health authorities with the lowest level of life expectancy. There are a disproportionate number of health authorities from the Northern and Yorkshire Region in this grouping.



The table below shows the infant mortality rate and the number of deaths in each area during 1999 for health authorities in the region. Clearly this is not the target, but does provide an indication of the scale of the issue at local level.

	Live Births	Infant Mortality		Neonatal Mortality (ages < 28 days)		Postneonatal Mortality (ages > 28 days)	
	Numbers	Numbers	Rate per 1000	Numbers	Rate per 1000	Numbers	Rate per 1000
Bradford	7157	59	8.2	33	4.6	26	3.6
County Durham	6450	46	7.1	32	5.0	14	2.2
East Riding	6026	34	5.6	23	3.8	11	1.8
Gateshead and South Tyneside	3752	21	5.6	11	2.9	10	2.7
Leeds	8170	50	6.1	31	3.8	19	2.3
Newcastle and North Tyneside	4885	18	3.7	15	3.1	3	0.6
North Cumbria	3205	22	6.9	18	5.6	4	1.2
Northumberland	3077	25	8.1	23	7.5	2	0.6
Sunderland	3111	16	5.1	8	2.6	8	2.6
Tees	6464	26	4.0	25	3.9	1	0.2
Wakefield	3643	16	4.4	10	2.7	6	1.6
North Yorkshire	7697	36	4.7	27	3.5	9	1.2
Calderdale and Kirklees	7546	55	7.3	32	4.2	23	3.0

Discussion

General

Considerable work has gone into the creation of simple targets that can be easily understood by the public and health professionals. It is highly significant that targets for reducing inequalities have been set for the first time and this has been widely welcomed.

The targets are wider than NHS indicators, needing to reflect wider determinants of health. Although the targets have been set for the NHS, they cannot be achieved solely by its own efforts but will require action on a much broader front; this should be viewed as positive evidence of the desire to find "joined-up solutions to joined-up problems".

One of the targets is area based and the other one is based on socio-economic group; this will create challenges for implementation. Although the infant mortality target is framed in terms of social class, action to deliver the target will be area based, but within these areas may be targeted at particular vulnerable groups.

Unlike virtually all the targets set in "Our Healthier Nation"¹⁰, these inequality targets are not a simple extrapolation of trends. The gaps between social classes for infant mortality rates and life expectancy across Health Authorities have been getting wider. Reversing the trend is likely to be challenging. There is, however, a need for specify achievement of the targets by levelling up, not levelling down (a measurable narrowing in the health gap should not be attributable to the healthiest group deteriorating).

While these are clearly national targets, which can only be monitored at national level (at least over the short term), there should be some scope for identifying contributions at local level. The Northern & Yorkshire Public Health Observatory has negotiated access to the life expectancy data and a regional extract of the infant mortality data (from the ONS Linked File) for local analysis.

The ranges of interventions are broad brush, which will make it very difficult to identify which interventions are making an impact and which are not. By working in partnership with local people, local government and local organisations the NHS can make a huge contribution to narrowing health inequalities. There is undoubtedly a need to target specific interventions at those most in need. "Our Healthier Nation"¹⁰ specifically states:

"Progress on national targets must not be secured simply by targeting social and ethnic groups whose health problems are more easily tackled."

There is an intention within the "NHS Plan"¹ to review the national resource allocation formula so that reducing inequalities is a key criterion for the allocation of resources within the NHS and this work is already underway under the auspices of the Advisory Committee on Resource Allocation (ACRA). However, in the meantime a smaller Inequalities related funding stream is in existence, allowing a broader allocation of funds previously targeted at a smaller number of areas, e.g. Health Action Zones. Although it is a relatively small allocation (£130 million), it is likely to be strongly performance managed.

Infant Mortality

Infant mortality is the number of deaths in liveborn children within the first year of life expressed per 1000 live births. The causes of infant deaths are multiple and complex; tackling infant mortality is likely to concern nearly all government departments, and includes tax and benefit policy, action by local authorities and interventions targeted at individuals' lifestyles and behaviour. No single course of action will serve to close the gap and, as the Department of Health states⁴, many of the causes of infant deaths are "not immediately amenable to intervention." Yet social class gradients are not inevitable - as Sweden attests¹¹. The proportion of infant mortality that is preventable needs to be separated from other causes of death e.g. cot death, social class gradient so that these factors can be targeted. There is also an ethnicity dimension to social class.

This target is based on a manufactured data set (the ONS Linked File - constructed by linking birth and mortality data sets), which is currently held by the Office for National Statistics. While this data set is not routinely made available, access to a regional extract has been negotiated and this is awaited.

At national level, projections suggest that achieving a 10% reduction in the infant mortality gap will actually require a reduction of 30% in the gap that could be expected in 2010, if current trends persist. In absolute terms, achieving this inequality target will not amount to very large falls in the number of deaths. For example, reducing the infant mortality gap between social classes by 10% implies a fall in the number of deaths for the lowest social class in 2010 of just a few tens, although in human terms this would make a significant difference. Analysis of the regional position will be undertaken when the regional data is received.

When the parents of a baby are married then either one alone or both together can register the birth. When the parents are unmarried then either the mother can register the birth as a "sole registration" or both parents together can register the birth as a "joint registration" but the father alone cannot register the birth as a "sole registration". Births with "sole registrations" have been excluded from the analysis and target setting process, as at present there is no technical solution to the problem of social class being dependent on male occupation. The new classification of social class that is being developed should improve current exclusions such as sole registered births and parents who are long-term unemployed (which do not fit into current social class groups). The sole registration data exclusions may skew the data in different directions e.g., professional women who are not married to their partners in one direction compared to other unmarried women and teenage mothers in the other direction. We could debate the degree to which these groups are likely to "joint register" or "sole register". Such groups are unlikely to be evenly distributed across the country. However, action in relation to teenage pregnancy¹² is operating with local targets, and this should help to redress some of the potential imbalance.

There are few people who would disagree with the sentiment of wishing to reduce infant mortality; however achieving such a reduction in mortality will not necessarily reduce morbidity and may serve to increase it, for example in surviving premature babies. The target and interventions as detailed give no recognition to "high risk groups" for which certain of the interventions may be more or less pertinent e.g., multiple births or extreme prematurity.

It is also unclear whether there is a general trade off between babies that are stillborn and those that survive birth and die in the perinatal or neonatal period. The target as set might have implications for management (i.e., whether intervention is made in the later stages of pregnancy or not). Infant mortality is heavily influenced by neonatal mortality and there is a need to separate out the trends for both. Neonatal deaths can be influenced by increasing mortality in smaller babies (i.e. a shift from stillbirths to neonatal deaths.)

Local monitoring is likely to include a combination of outcome and process measures.

The Government has said² that there will be targeted help for pregnant women to give up smoking because of its correlation with miscarriage, low birth weight and high levels of perinatal death. Babies from the most disadvantaged social groups have a higher death rate from Sudden Infant Death Syndrome compared to babies from more advantaged backgrounds. Mothers from disadvantaged backgrounds will have extra support by extending postnatal care by midwives to help improve rates of breastfeeding and early detection of postnatal depression since both can have a profound effect on the future of the child. Therefore there will be higher numbers of nurses, midwives and health visitors trained. There will be increased investment in neonatal intensive care provision and a new National Service Framework setting in place new national standards for children's services.

Life Expectancy

The monitored group (i.e., the 20% worst Health Authorities) may be different for each three-year period. Possible future Health Authority mergers or boundary changes may make this target difficult to track over time. Life expectancy is heavily influenced by socio-economic factors and correlates well with indices of deprivation and income distribution. To close the inequality gap requires action at all ages and it is heavily influenced by infant mortality.

Cancer and coronary heart disease are the country's biggest killers and better outcomes will make the biggest contribution to improvements on overall life expectancy. Since both killer diseases have such strong social class gradients a concerted effort to reduce preventable deaths among the most disadvantaged in the community will help realise the new target and it is in prevention that the biggest gains can be made.

The Government has said² that it will take more action to tackle smoking, the principal avoidable cause of death in this country. Smoking is the principal cause of the inequalities in death rates between rich and poor. It kills 120,000 people and costs the NHS up to £1.8 billion a year. A £50 million public education campaign and more direct action to help the 70% of smokers who say they want to give up will aim to reduce smoking prevalence. Health authorities will be targeting those groups with the highest smoking rates with the aim of helping at least 1.5 million smokers to give up during the course of this decade.

There will be work with food retailers to increase access to fruit and vegetables in deprived areas and to target communities poorly served by food retailers at present. Children in low income groups are less likely to eat fruit and vegetables than those in the highest income groups. 80,000 children across England will now receive a free piece of fruit each day at school as part of the Government's drive to improve child health. For some children it will double their intake of fruit. The intention is that by 2004 every child in nursery and every child aged four to six in infant schools will be entitled to a free piece of fruit each school day.

There will be also be new screening programmes to reduce the risk of disease. The breast screening programme will be extended to women aged 65-70, with 400,000 more women being screened every year. The feasibility and public acceptability of a national colorectal cancer screening programme is currently being tested. By 2004 there will be screening programmes for women and children including a new national linked antenatal and neonatal screening programme for illnesses such as sickle cell disease.

In the next financial year, £130 million will be allocated to the 50 or so health authorities where years of life lost are highest. In 2003/4 there will be the introduction of a new funding formula for distributing NHS resources across the country. Its driving force will be an assessment of the health needs of different communities. Reducing inequalities will be a key criterion for allocating NHS resources under the new formula. More primary care services in deprived areas will be developed principally through the new PMS contract and more salaried GPs.

For the life expectancy target, the reduction will need to be in the order of 25% for both men and women, as the gap across Health Authorities has been widening. Local targets will be set and localities will need to establish a balance between longer and shorter-term targets for a number of reasons:

- Results and achievements may need to be visible in the short term in order to build and maintain public support for policy action and to retain the continuing motivation of the various agencies and organisations involved in tackling health inequalities.
- Localities may need to set more process or action-oriented targets in the short term, for example establishing effective partnerships or the collection of joint data, as part of ensuring that longer-term goals can be achieved.

The problem of creating perverse incentives will also need to be considered. For example, a locality could set a target to increase the uptake rate of a preventive service amongst one particular group, which could lead to other population groups being neglected in terms of services or resources.

Conclusions

That the Government has set national targets for tackling inequalities in health should be viewed as a positive step. It is recognised that the targets as set are limited to a certain extent by technical definitions (particularly in relation to social class) and by the format of the data that is currently collected. The Department of Health is aware of these limitations and will seek to overcome them over time and thus improve the sensitivity of the targets.

The ranges of intervention proposed in the supporting documentation for the targets⁴ are broad in scope (in recognition of the complex and multiple causes of inequality) and are untargeted. The exact means by which interventions should be undertaken and targeted should thus be determined at a more local level, based on a better understanding of the populations involved. The NY^x Board on Inequalities could have a valid role in this respect.

NHS organisations, particularly Primary Care Trusts will need to be encouraged to take a whole systems approach to the achievement of these targets. There will be a temptation to focus on NHS interventions (e.g. smoking in pregnancy, health interventions to increase life expectancy). Whilst these are important and should be undertaken, potentially a greater impact will be achieved through the reduction of poverty and social regeneration. The latter are clearly more complex and multifactorial, but NHS organisations are well placed to use their influence to achieve changes in these areas as well as in their more traditional areas of responsibility.

A clearer understanding of the regional baseline position will be possible, once the appropriate data has been received from the Office for National Statistics. A regional analysis of this data will be forwarded to the NY^x Board on Inequalities once completed.

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